



Indiana's Prescription Drug Plan for Seniors



State Form 49905 (R4/8-02) PDP 0001

What is HoosierRx?

HoosierRx is the state's prescription drug plan for seniors, created by your state legislators and Governor Frank O'Bannon, to help with your prescription drug costs. HoosierRx is funded by the Tobacco Settlement funds and covers most prescription drugs, as well as insulin.

HoosierRx is a drug card program. If you are eligible for the HoosierRx Drug Card, you will get 50% (or half) off the cost of your prescription medications directly at the pharmacy, until you meet the yearly limit. After the yearly limit has been met, you will still receive the HoosierRx rate on prescriptions, if you continue use the HoosierRx Drug Card.

Are you eligible?

- You must be age 65 or older.
- You may NOT have any prescription drug coverage through an insurance plan or through Medicaid, including Medicaid with a spend-down.
- Your monthly income must be:
 - Single person – \$997 or less
 - Married couple – \$1,344 or less

1-866-267-4679 (Toll Free)
www.IN.gov/HoosierRx

How much of a benefit will you receive?

Benefit amounts are determined by the senior's net monthly income and family size.

- If you receive a monthly income of \$997 or less for a single person, or \$1,344 or less for a married couple, you could receive 50% (or half) off of your prescription costs, up to **\$500** in a year.
- If you receive a monthly income of \$886 or less for a single person, or \$1,194 or less for a married couple, you could receive 50% (or half) off of your prescription costs, up to **\$750** in a year.
- If you receive a monthly income of \$739 or less for a single person, or \$995 or less for a married couple, you could receive 50% (or half) off of your prescription costs, up to **\$1,000** in a year.

After the yearly limit has been met, you will still get the new HoosierRx rate on prescriptions, if you continue to use the HoosierRx Drug Card.

How do you apply for HoosierRx?

Apply now by using this short application. Send us your application with your income documents. If you are eligible, you will receive your HoosierRx Drug Card and instruction on how to use your card at the pharmacy.

Application for the HoosierRx Drug Card

This application continues on the back side.

Who is Applying for the HoosierRx Program? ☐ Just you ☐ You & your spouse (Must be age 65 or older)

Information About You:

Your Name: _____ Telephone: (_____) _____ - _____
(First name, middle initial, last name)

Date of Birth: _____ Your Social Security Number: _____ Sex: ☐ Male ☐ Female
Month - Day - Year

Mailing Address: _____ City: _____ State: _____

ZIP Code: _____ Race (Optional): _____ Marital Status: ☐ Single ☐ Married ☐ Widowed

Other Mailing Address: (If different than above) _____
(Other Authorized Name, Address, City, State, Zip Code)

Other Telephone: (_____) _____ - _____

Information About Your Spouse: (If married and living together, you must complete this section and send copies of the monthly income for you and your spouse, even if only one of you is applying for benefits.)

Spouse's Name: _____ Spouse's Date of Birth: _____
(First name, middle initial, last name) Month - Day - Year

Spouse's Social Security Number: _____ Spouse's Race (Optional): _____

Information About Your Dependent Child/Children:

(If you have any dependent children, you must submit specific information about that child(ren) on a separate piece of paper and attach it to your application. For each dependent child, please provide the child's name, date of birth, social security number and documents to prove income for that child. Remember, a qualifying dependent(s) is either your biological or adoptive child (under 18 or a student 18-21 years old) or a child for whom you have legal guardianship/custody through a court. If you do **not** have any dependent children, please move on to the next section.

This application continues on the back side.

Income: (Important, Please Read)

You must attach documentation or proof of your family’s monthly income, or your application will be denied. If you are married, you must attach documentation or proof for both yourself and your spouse, even if only one of you is applying for HoosierRx. Please attach all income documents to your application.

Along with your documents, please provide the monthly amount you or you and your spouse receive for each of the following: (If you do not receive the listed income, please leave the line blank.)

	Applicant (You)	Spouse
1. Social Security (minus the Medicare Part B premiums), Supplemental Security Income and Railroad Retirement income.	\$	\$
2. Pensions, retirement income, annuities, veteran’s benefits	\$	\$
3. Interest and dividends (If joint accounts, please place amount under the ‘applicant’ column only.)	\$	\$
4. Other income (wages, rental income, non-taxable income.)	\$	\$
Total	\$	\$

Remember, you must send documents of your monthly income or your application will be denied.
(Examples of documents that show your monthly income include copies of bank statements and award letters.)

Your Insurance Information: (Answer all questions or your application will be denied)

Do you receive Medicare? (Yes or No) _____

Are you on Indiana’s Medicaid program or on Medicaid with a spend-down? (Yes or No)_____

Do you have an insurance plan that helps pay for prescriptions? (Yes or No) _____

What is the name of this insurance plan? . _____

Explain how your insurance plan helps you pay for your prescription drugs: _____

Do you actually have a prescription drug discount card? . _____

Your Spouse’s Insurance Information: (Complete only if spouse is applying as well.)

Does your spouse receive Medicare? (Yes or No) _____

Is your spouse on Indiana’s Medicaid program or on Medicaid with a spend-down? (Yes or No) _____

Does your spouse have an insurance plan that helps pay for prescriptions? (Yes or No)_____

What is the name of this insurance plan? . _____

Explain how your spouse’s insurance plan helps pay for prescription drugs: . _____

Does your spouse actually have a prescription drug discount card? _____

Please read the information below, sign and mail with the necessary documents of your monthly income:

I understand that I/we must complete this application in full or this application will not be accepted. I understand that information I/we provide is confidential and will not be disclosed without my consent for any purpose that is not related to HoosierRx (PL 42 USC 405(c)(2)(C)(i)/IC 4-1-6-2/IC 4-1-8-2). I authorize Medicaid to release information about Medicaid eligibility to HoosierRx. I have lived in Indiana for at least 90 days in the past 12 months. I certify, under penalty of perjury, that all of the information I have provided is complete and correct to the best of my knowledge.

_____ Your Signature	_____ Spouse’s Signature (if applying)	_____ Date
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Did you remember to:



- ☐ Fill out the front of the application;
- ☐ Answer all of the insurance questions, including the question about Medicaid;
- ☐ Sign the application; and
- ☐ Attach your documents/proof of income?

Send your application and income documentation to:

HoosierRx
P.O. Box 6224
Indianapolis, Indiana 46206-6224

Where did you hear about HoosierRx?

- | | |
|--|---|
| <input type="checkbox"/> Area Agency on Aging | <input type="checkbox"/> Pharmacy/Drug Store |
| <input type="checkbox"/> Doctor’s Office | <input type="checkbox"/> Presentation |
| <input type="checkbox"/> Energy Assistance Program | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Legislator | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Meal Site | <input type="checkbox"/> SHIIP |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Social Security Office |
| <input type="checkbox"/> Minority Health Coalition | <input type="checkbox"/> Television/TV |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Township Trustee |
| <input type="checkbox"/> Office of Family and Children | <input type="checkbox"/> Other _____ |



Questions? – Call us toll-free at 1-866-267-4679 or visit our web-site at www.IN.gov/HoosierRx